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Chapter 21 Questions & Answers October 11, 2007
Questions submitted by Providers - Answers provided by DHHS Developmental Services (October 10, 2007)

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Question	Provider Integrity Unit	Office of Adults with Cognitive and Physical Disability Services
We understand the providers are expected to retain payroll records, staff schedules and programmatic documents to verify service provision under Chapter 21. With regard to the staff schedule, are you expecting to see a document which shows actual coverage – i.e. if a staff person calls in sick, do you expect to see a document which specifies by name, the employee who covered for the sick employee?	Not required to retain staff schedules, however, staff schedules would be helpful in verifying services were provided. Do require documentation which shows the proper staffing is in place for individual/s.	Same
In some instances under the present system, individuals residing in a 24/7 home support arrangement, have had additional support hours approved in order to	Require documentation which shows proper staffing was in place for individual/s. Such as shift notes with sign in and sign out times and indicate that service/s listed in the service plan were	Require documentation which indicates that service/s listed in the service plan were provided. Include: If plan states the person will go out to day program but does not - such

provide individualized "whole life" support. We have been expected to provide documentation that the identified individual received those hours. Chapter 21 appears to merge all staff hours and spread them equally across all residents as a blended rate. What are the documentation expectations in these instances?	provided. In home support services that are not the usual rotating shift model, the agency's policy must define what documentation is expected for the blocks of time that reflect services were provided in accordance with the person's plan.	as ill, elderly -then the expectation is that documentation will reflect that the service occurred in the home or what activity took place in the home. All staff that are covering for a time period must make a note stating activity and time.
Some individuals will have medical and/or behavioral add-ons in their authorizations. What are the specific documentation expectations for the add-on portion of the rate?	Documentation will be reflected in the individual's plan. Behavioral will be in the note as prevention activity. Medical will be in the note as medical activity. These activities should be in response to what is listed in the medical or behavioral add on.	Documentation will be reflected in the individual's plan. Behavioral will be in the note as prevention activity. Medical will be in the note as medical activity. These activities should be in response to what is listed in the medical or behavioral add on. The team will set up some type of system to collect data to monitor effectiveness of the add on
Regarding work-related activities; Home supports: There are no prohibitions stated in the draft rules about providing home supports in a work setting, can we assume that this is not prohibited, similar to our current use of personal support in the workplace? Community supports:	A DSP can provide home support at home. This service is billed as home support. A DSP can also provide work support in the work setting. This service is billed as work support. Billing cannot be duplicated. For example, if a work support staff comes into the home to get an individual ready for work then he/she can bill as work support but the home support person cannot bill for the same time. Documentation should reflect the appropriate	Assisting in the work setting is different than assisting at home. There is an additional, increased atmosphere of professionalism required in the workplace. The culture of the work setting must be respected.

While we understand that these supports cannot be provided in the workplace, information on the OACPD web site regarding Chapter 29, discusses a variety of allowable activities entitled "Path to employment". Are these same activities appropriate to bill as community supports under Chapter 21? 5. With regard to those services which have a quarter hour rate which is then rolled into an hourly rate or a per diem, what it the expectation with regard to documentation of services?	services provided. B.Yes Please refer to Question #2.	
In instances where residences have staff on duty overnight, either as required by entities such as the State Fire Marshall, or due to an individual's need for assistance intermittently during the night, what is the content and frequency of documentation required? With regard to the above question, is there a difference in expectation if staff are permitted to sleep during those overnight hours?	Notes should reflect according to what and when something did or did not happen. If nothing happened then a shift note can be made stating that nothing happened during the night. No. Documentation must reflect that staff was there and when and if something or nothing occurred. Mom & Pops need to work on documentation reflecting person, plan and per diem.	Notes should reflect according to what and when something did or did not happen. If nothing happened then a shift note can be made stating that nothing happened during the night. Chores are allowed to be done during a shift, however, that is not what is being billed -only activities related to direct assistance to the individual. Do not make notation in individual's record that you did chores. This type of documentation does not support why the staff are on duty.
We have some confusion around how to best reconcile documentation	Same response as Question #2.	

for the individual served and billing based upon staff hours. What is the content and frequency of documentation for each individual? For example, in a four person living arrangement, an agency would be billing at a perdiem rate which allocates staffing hours at the rate of 25% per individual. Is the expectation with regard to documentation in the programming record of each individual that this will tie back to the 25% share of the total hours?		
During the shadow process, agencies were encouraged to bill on a monthly basis in order to allow for an averaging of direct support time over a longer period than a week. From an audit perspective, what is the acceptable period of time to determine the range in which to bill?	The billing methodology is the choice of the Provider. The Provider Integrity Unit will expect documentation that services were provided in accordance with the person's plan regardless of frequency/method of billing.	Detail about billing methodology has been built into Section 21 Chapter 3 rules. The 3X3 committee spent time crafting the wording for monthly vs. weekly and partial week billing instructions.
If a provider has an electronic time keeping system which shows when an employee punched in and punched out, is retention of the staff schedule necessary?	Must make notes to ensure that services that are being paid for are being given. See #1.	

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Document #1

Q1: As discussed, in order to bill providers need both a procedure code number [supplied in Jane's Section 29 e-mail) **and** a provider number for that service. We do not have provider numbers for the new procedure codes, so we will not be able to bill for these services. This might be a question that MECMS rather than *the state agency formerly known as BDS* can answer, but we are trying to consolidate questions.

A: DHHS Provider File Unit, Rate-setting unit and the DS Resource Coordinators developed a list of the "old" procedure codes and corresponding provider ID number. In order to save providers from having to re-apply for new numbers, they then cross walked the ID number to the new procedure code and sub-specialty. This work will be reflected on the Summary of Authorized Services and will be reviewed for correctness with the Resource Coordinators.

Q2: Can the Department please clarify under what circumstances will DSP time to accompany a consumer to and from MaineCare covered services be billable (within the authorizations, of course). More specifically, to and from Community Supports and Work Supports?

A: If the consumer requires supervision during transportation then the DSP time is billable within the limits of the authorization.

Q3: In Community Supports, is the billable unit the consumer time (measured in quarter hours) and not the DSP time?

A: Yes, it is the consumer time that is billable and it is billed at the rate dictated by the program staffing ratio and at the corresponding published rate.

Q4: We are an agency which provides employment, community, and home supports. Years ago, when agencies began doing the PCP coordination, our rate increase was based (in part) on doing the PCPs for people supported in work and community who lived in what will now be known as Family Centered Support. Does the Department expect that

the homes will become responsible for the PCP process when rate setting is implemented?

A: No, the FCSM homes are not responsible for the PCP process. The agency providing work or community support have rates that include reimbursement for this in their rate so it is their responsibility.

Q5: Will DHHS implement a tool such as the Support Intensity Scale?

A: Yes, DHHS expects to include a standardized assessment tool as a companion to the published rates in the future.

Q6: There is concern that the Behavioral /Medical Add-Ons will be based on the vagaries of the individual ISC who doesn't know the consumers as well as our direct line staff do. For example, We may believe that one of our consumers will qualify for a Behavioral Add-on because of her daily challenges. However, there is concern that another might not because we've helped to greatly reduce his behaviors by careful staff management and training. If that's not recognized in the rate system, there is fear that people will regress. We're working with the PCP and documentation process to reflect needs. There is the concern about a 3 year limit on a behavioral add on. We have found that residents do well because of the extra staffing and when it is pulled we see the decline and increased staff injuries. The add-on becomes especially important for consumers who have a dx of pedophilia--also fire setting, pica, to just name a few. These dx and behaviors will not disappear after 3 years. Will agencies be allowed to reapply for an extension of the add-on or is it only a one shot deal??

A: Please review the appendices in Section 21 and the corresponding protocols for Behavioral and Medical add-ons. The determinations will be requested by the providers and the final decision will rest with a team comprised of a mix of central and regional DHHS staff. This question seems to mix two separate and distinct processes. "Extra staffing" is addressed in the process of authorization; i.e. how many hours of support are authorized in support of an individual's needs. The "add-ons" for either behavioral or medical reasons, do not increase the authorization; they bump up the rate of reimbursement in recognition of additional administrative costs.

Q7: How can providers check to verify the rate that is in MECMS? Because of the many iterations of rates, with and without the provider tax added, there is the need to have an electronic resource to check rates.

A: Providers will receive a print-out of the rates and authorization that are contained in EIS. These are the rates that will electronically feed into MeCMS. After implementation of published rates, there will be no distinction between rates with or without the service tax. For services that have an associated tax, the tax will be <u>included</u> in the published

rate. After December 29, 2007 the "Summary of Authorized Services" will only show one rate.

Q8: Is it true that only services delivered by a certified DSP will be allowed? There is no test out as far as we know and with turnover, the 40 hour course is difficult and expensive. Staff must have worked in the field for 2 years.

A: Yes, only services provided by a DSP are billable. The test-out option will remain in place. New employees will have one year from date of hire to successfully complete the DSP curriculum.

Q9: In supported employment, if there is a job change that does not rise to the level of a VR referral but needs additional Employment Specialist time can we substitute (without approval from Augusta) the employment specialist time for work support time as long as we stay within the 600 hours and under?

A: There is a limit of 10 hrs. per month for Employment Specialist Services. The maximum authorization on an annual basis is 120 hrs. per year. If a consumer is authorized to receive up to this limit (or any other authorization number), the delivery of the service can be as required by the consumer, as long as it remains within the authorization. The total number of authorized (and delivered) hours of the two services combined cannot exceed 600.

Q10: Will providers need a medical add-on policy?

A: No.

Q11: What is the plan for "sheltered" work? Should we continue to bill under the grant?

A: Until the Section 29 Support Waiver becomes effective, The Department will amend contracts to pay for sheltered work.

Q12: Do personal supports fall under the 1300 hour cap or are they considered residential?

A: Personal Support Services is not a service that is provided under this Waiver. What was previously known as Personal Support (W125) is now Home Support. The 1,300 hour limit does not apply to Home Support.

Q13: Is participation in events, activities, and other life experiences a covered service? Examples include, but are not limited to, community events, consumer vacations, consumer participation in special events, special trips, Special Olympics, and SUFU??? If they are a covered service (staff time is billable), then how are the participation fees, travel and accommodations costs of the consumer and the staff to be handled?

A: If the activities are recommended as a part of a person's plan and support/supervision is required, then the staff time is billable. Within the rate structure, "program related expenses" can be used to offset some participation fees. Depending upon the specifics of the travel, there may be some reimbursement already built into the rate; e.g. trips to local community activities/functions that are provided during Community Support hours are factored into the rate.

Q14: What type of "year" is used for authorizations and how should providers track utilization of authorized units?

A: Authorizations are generally done for a year's period of time, usually at the time re-classification. There may be exceptions to this, most commonly if there is a time limitation for some reason. If there is a limitation, the "Summary of Authorized Services" will show an end date. As this Waiver operates on a state fiscal year (July-June) and is funded and reported on accordingly, providers should track utilization on a fiscal year. An example: The annual limit of Community Support hours is 1,300 per year. This count should commence on July 1.